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LEADING ARTICLES

NEUROSES OF THE BLADDER.*

ROBT. C. M. LEWIS, M. D.

MARION, O.

THE purpose of this paper is to consider, somewhat briefly, a few of the neurotic conditions which are traceable to the genito-urinary organs, especially those involving the vesical neck, and the deep, or prostatic urethra. In presenting the subject no attempt will be made to follow or make any regular order or classification of the numerous neurotic conditions with which we meet. Many able investigators have passed over this territory, and each have apparently left plenty of virgin soil for their followers to cultivate, and it seems that no one subject will wake up the apathetic, slumbering, would-be critic more promptly than this.

Some of my hearers may feel disposed to criticise the writer because of frequent quotations from authorities farther up in the ranks, but I have no apology to make when I use the names of such men as Lydston, Keys, Ultzman and others of their class, as authority on this, my chosen subject, for I am but one of the hundreds, yea, thousands who quote from their writings daily. The conditions that take first place in neurosis of the bladder, I presume, might be considered under the head of hyperesthesia and neuralgia of the vesical neck. It is claimed, I believe, that the nervous element of hyperesthesia of the deep urethra and vesical neck bears a large share in producing the symptoms of nearly all bladder diseases. Many of the nerve racking neurasthenic symptoms frequently met with are traceable to the neck of the bladder, because of the rich supply of nerves in the prostatic region.

ROBT. C. M. LEWIS, M. D.,

Hyperesthesia is often misleading because of certain symptoms in common with inflammatory disease. In neurotic bladder troubles I am giving first place to hyperesthesia because I believe it is met with more frequently than any other of its order. As already stated, hyperesthesia is often misleading because of certain symptoms in common with other affections, but I believe Lydston has drawn the line sharp and distinct between hyperesthesia and neuralgia, for neuralgia in its true form has some very clearly defined outlines, though in connection with other bladder and urethral disease it may for the time confuse the diagnostician. Ultzman has described the general as well as the local symptoms of a hyperemia or chronically in-

*Read before the Mississippi Valley Medical Association at Columbus, O., October 10, 1907.

flamed prostatic urethra. He claims that conditions just mentioned, as found in the male will furnish symptoms almost identical with those in the female suffering from endometritis. A study of the intricate nerve supply of those parts readily explains why irritations of the prostatic urethra should excite reflex pains on the inner surface of the thighs, or in the hips, the anus, or the hypogastric region and the lower part of the back. The general symptoms then complained of by the neurasthenic female will be duplicated in the male suffering from hyperesthesia of the bladder or from irritation of the deep urethra. Years ago the elder Keys made the statement that the nervous hypochondrin with despondency, the excited and suspicious so marked and remarkable in nearly all men at any time of life in connection with functional or organic trouble in the genito-urinary tract, are only explicable by recognizing that nature has implanted in man a sexual want which controls many actions of his life. It impels him to continue his species, and cries out in distress whenever it is trifled with, ungratified, or over-stimulated, or whenever its existence seems to be menaced. A man will feel more depression at seeing a little excess of phosphate in his urine, which he thinks, in spite of all proof to the contrary, indicates a local weakness, than he will at the loss of memory or mental incapacity which he can himself recognize and be fully conscious of. There are few men who would not rather lose a leg, or an eye, than a testicle, while functional or organic disease of the bladder, testicle or penis cause more mental inquietude and distress to its possessor than does a cavity in a lung.

Why should this be, except that nature has endowed man with an instinct of terror at the idea of losing his sexual capacity, and has established a law for the regular and judicious performance of the sexual act which he must obey or in some way suffer the penalty. We find the female often ready and willing to sacrifice her ovaries on account of a real or an imaginary disease. She may be young, with life's pathway fairly strewn with roses, yet with some neurotic trouble and on the advice of her physician, she will almost joyfully mount the operating-table and undergo emasculation.

But not so with the sterner sex, for we find the old man, when the luminary of life is descending, when it has dropped down almost to the sky line, perhaps long after desire has failed, and when he suffers from senile hypertrophy, he makes the fight of his life for a pair of old testicles which are useless, and not even ornamental. Age plays no figure in the question of mental distress where affections involving the genito-urinary organs are concerned. The middle-aged intellectual giant quails and dwarfs under the punishment of a hyperesthesia, or a neuralgia, or a catarrh of the bladder, and we know of nothing in the category of disease which can produce so much mental worry and physical distress as the above mentioned disease.

Mental worry, or over-tension of the nerves for a long period may produce a vesical hyperesthesia with a certain train of symptoms simulating a true cystitis as a rule, if there is no inflammation, the absence of mucous or muco-pus in hyperesthesia will give us a line of distinction so that cystitis may be excluded as a complication, or as a sequel to other diseases of the bladder we find perhaps no other which gives so much mental and physical discomfort as hyperesthesia. In these cases the urine may be neutral, acid, or even phosphatic, a matter which depends largely on the cause of the hyperesthesia, but there is almost a constant desire to urinate, and a feeling all the time that the urine will escape during the intervals between the acts of emptying the bladder.

We might here mention one point which may be relied on as a distinguishing characteristic in vesical hyperesthesia, (and which certainly is not true of cystitis) is that the sufferer may go to bed and have a reasonable degree of assurance that sleep will not be interrupted by frequent calls to urinate. When the mind is occupied, even in waking hours, the trouble is much less, but in sleep the irritability is always in abeyance. A neuralgia of the bladder may or may not be associated with hyperesthesia. A neuralgia may be brought about by similar conditions that will cause hyperesthesia, and often is associated with or follows after some inflammatory disease of the bladder or deep urethra.

I have on my books now the name of a man, aged about 40 years, who has for the past four or five years suffered almost the torments of the damned from a neuralgia involving the vesical neck and reflected down in the left testicle. He is apparently well in every other particular. He has a history of a cystitis dating back several years, and neuralgia in this form is a sequel. The two are never together. An attack of the cystitis may come, and after a treatment subside only to be followed by an attack of the neuralgia, which may punish him for days and leave it as promptly as it came. After these paroxysms have passed it generally takes several days for him to recover from the nerve-racking that he has undergone. This man is highly intellectual, of good habits, and absolutely free from venereal taint, but

in his younger days he frequently allowed his erotic fancies to get in the ascendency and eventually, following an attack of influenza, he suffered an attack of cystitis and in the wake of the latter came the neuralgia. Sexual distress is no doubt a potent factor in forming a back-ground for both hyperesthesia and neuralgia. Bachelors, old maids, widows (and I believe priests are also on the list) suffer from sexual distress, though many of them may not give out local signs of the trouble. This class of patients are treated often for a legion of ills from which they have never suffered, for their symptoms may be scattered over all the adjacent organs and may impair their functions materially. Sciatica is a common following of cystitis, and as the latter becomes chronic all efforts to control the former will be futile until the bladder is in a measure remedied of its inflammation.

We cannot make a review of this portion the nervous system here. We do recognize the possibilities of pelvic reflexes and urge all who meet with this class of cases here under consideration, to observe carefully these nervous manifestations, especially in women.

Reflexes, leading estray gynecologists of ability, have been found, not in the uterus or ovaries, but in the urinary bladder. A form, coccyalgia, and troublesome in the extreme, is frequently found among women who have had an injury to the vesical neck, by reason of a prolonged and difficult childbirth. I have known a few who have been promptly relieved from this distressing symptom when proper attention has been given the bladder. I think that many of the thousands of women who were unsexed a few years ago, when the craze was on for ovariotomies, when every man who could wield a knife and locate an ovary was making a record, might today be happier, had their bladders been treated and allowed to retain their ovaries. I believe it is Krause that urges a thorough examination of the genital tract as a routine practice in every case of neurasthenia, claiming that bad sexual habits are the cause of a large proportion of the neuroses, and advises against giving a favorable prognosis in cases of nervous disease with an underlying history of masturbation coupled with a neurotic family history. Gynecologists, find frequently conditions that their best efforts fail to relieve, because of some distortion of the pelvic mechanism has changed, perhaps the position of the bladder. Malposition of that organ will sometimes compromise circulation by strangulation of blood vessels, and malnutrition follows. Under such conditions a train of symptoms so complex and misleading confronts the gynecologist that he may well be excusable for making a mistake, but may have reason to rejoice with his patient, should he by chance direct his attention to the vesical neck.

Granular urethritis near the neck of the bladder is another condition we must not lose sight of as a cause of aggravating neurotic troubles. The reflexes resulting from this condition, especially among females (though it is common among males who have had prolonged and badly treated gonorrheas) is certainly capable of bringing about a line of symptoms so complex and obscure that we may well be charitable to ourselves as well as to our colleagues when we or they err in diagnosis. Discomfort in voiding urine as one of the numerous associated symptoms, is quite a common subjective complaint in women of the neurotic class, and in hyperesthesia or irritable bladder from any cause there is often the vesical pain and spasm, but in no one of the urinary disorders found among women do we find the reflexes so well marked as in granular urethritis. In this trouble, as in neuralgia of the bladder neck, with neurotic women, unless diagnosis is made by exclusion, the gynecologist, especially, may be led by "will o' the wisp" in the direction of the uterus. He may look for cancer of the cervix, metritis and all sorts of ovarian trouble. In these cases the same point of irritation may cause paroxysms of what may appear to be mucous colic and simulate even membranous enteritis,. Dysuria may, and frequently is caused by proctitis, dysentery and hemorrhoids, but on the other hand, we find reflexes coming from the irritable bladder, that will often cause apprehension as to the colon and rectum. I believe it is generally conceded that the principal seat of the desire to urinate is in the mucous lining of the true vesical neck, the deep urethra, therefore it is quite reasonable that we should, on first examination, look there when troublesome reflexes are encountered. Inflammatory conditions of the bladder may exist in quite a large per cent of hyperesthesias of long standing, because of the dysuria and spasmodic squeezing and consequent bruising of the vesical neck. Many of these patients suffer either from sexual excess, or from ungratified sexual desire, and in such cases the reflex symptoms are frequently legion. It would take up too much time here to consider all the various neuroses of the bladder and sexual centers for they may be either sensory or motor, and the sensory alone present almost an infinite variety. Atonic impotence is an important one, and the general symptoms are those of neurasthenia; in those cases one of the most troublesome symptoms is the sensation as though

fluid was trickling through the urethra, a burning and itching sensation at the meatus, neuralgia and burning pains in the testicles. The feeling that the urine is escaping is to the fastidious patient one of great punishment; the impending fear of wetting their clothing is always present. With such subjects, the vertigo, headache, indigestion, nervousness, and loss of mental power are all well marked. The impotence common in chronically inflamed conditions, either of the bladder or the deep or prostatic urethra are usually of the motor neurosis, and present almost as great an array of general symptoms as the sensory. Prostatorrhea and incontinence should both be taken up here, but time forbids, for the latter is a condition that we encounter so often in both the adult and the young, that we could not do justice to it here. One other condition should not be overlooked, and it is not so infrequent as many suppose, that is fissure in the neck of the bladder. This, I think, is much more common with the female than is generally supposed and can produce a great amount of mental and physical worry, but the prognosis is always good.

I wish to say to you at this point, though I have in a way accused some who specialized along other lines of erring in diagnosis with diseases of the genito-urinary tract, I mean no affront, but give to them such as we have meted out to ourselves, and all others who seek with a hope of finding. I say this, and I believe I am right, else I would not make the statement, that we can find more men in our profession groping in darkness along this line than you will find in many other of the commoner branches of our work.

Don't you know, gentlemen, that it is a fact that you may begin a discussion with the average physician and surgeon (I say average, understand) and he will intelligently talk on the subject of obstetrics, general surgery, bacteriology, the eye and ear, and perhaps the fitting of spectacles, but take up genito-urinary diseases, and he will consider briefly cystitis and gonorrhea, halt at that point, perhaps take a chew of tobacco, and calmly inform you that he has a call to make. This should not be, and in the future will not be, for our medical schools are making better provision for instruction along this line, and are securing the best talent for those chairs. The cry has come from Macedonia and elsewhere for help, and it is being heeded. Our habits of living have much to do with the development of these disorders, and the subject is one of vast importance. I am not here today laden with specifics or pet treatments for the diseases which come under the head of this paper, for I have long since learned that if we men of medicine and surgery have once a clear conception of a disease, of its symptoms and its pathology, in fact, able to make a diagnosis that can not readily be questioned, then the matter of treatment is one which may be considered somewhat deliberately, and as a rule quite satisfactorily for both patient and physician. It is when we err in diagnosis, when we are at sea, as it were, when we in our ignorance of a condition, are entangled with the complexities of a legion of reflexes that the false lights of the ignis fatuus lead us into deep water.

THE KIDNEY, SURGICALLY CONSIDERED.

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ANDERSON, INDIANA.

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THE kidney as a functionating organ is worthy of a great deal more attention than is given it by the general practitioner. It is also liable to become a nightmare to the patients who consult our specialists. The kidney probably more than any other organ reflects the general systemic condition. Every infection or indisposition can be followed by an increase, a decrease or a change in the kidney function. Those who study this most closely, find most wrong. It is rare that a urinalysis will ever show a perfect functionating kidney so far as an exact quantitative and qualitative analysis may determine.

Hence medically considered, we must take the kidney not pathologically determinative, but as indicatory; a danger sign which if not heeded may precipitate a fatal wreck. We must take cognizance of its defect, but more than that we must consider its general sufficiency. We find like wise that the abdomen and its viscera are capable of showing many inconsistencies and our authorities are frequently paradoxical as to statements of fact.

The specialist is a necessity, but it frequently means that the findings of the specialist are to be interpreted by the conservative general practitioner. We hear of our optical friends curing gall stones with nose glasses; our gynecologists preventing insanity by castration; our serum fadists eli-m inating locomotor ataxia from the list of incurables, while the conservative surgeon

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has to answer for the failures and the faults of many doctors who operate.

The kidney, properly speaking, is not an abdominal organ. It is retroperitoneal and subcostal, or rather was, until it became dissatisfied with its posterior position and sought to become more prominent by moving forward, or downward or inward, to the detriment of intra-peritoneal organs and their proper functions.

Floating kidney has become fashionable and society demands much of its physicians. Those, however, who are learning the art of diagnosis, are unfortunately finding many cases among the women of the middle and poorer class. Many cases of confinement are succeeded by a period of indisposition for which I can find nothing to account save a visceral ptosis in which the kidney is markedly dropped.

I can remember with what awe we used to see Professor Senn palpate the kidney and hear him roll his R's when he told us how to do it by Isereal's method, and later saw him fix it in place by Simon's method. The kidney, I then inferred was a Hebrew luxury. Dr. Bevan, however, in an article entitled "Unnecessary Surgery," and published this year, states that he is able to find nephroptosis in 85% of the women he examines. The human form is following the ill-fortune that was prophesied for it so many centuries ago; we are becoming wiser at the expense of physical strength. Cellular resistance seems to be at a minimum. Nerve and fibrous tissue relaxes at the slightest irritation. We need puckering strings in our heads to avoid brain storms and our feet are crippled and require arch supports, while the woman who is not gill flurried is as rare as the virgin. Movable kidney should be considered foremost in importance because of its commonness, and were I to make any definite surgical conclusion it would be that only one of many of them should be surgically considered. In the American Journal of Surgery for January, 1907, Dr. Robert T. Morris classifies these cases as follows:

1. Loose kidney present, but causing no disturbance.

2. Patients with minor psychosis associated, but not dependent upon the presence of a loose kidney.

3. Patients with minor or major psychosis precipitated or intensified by the presence of loose kidney.

4. Patients with various reflex gastro-intestinal disturbances depending upon the influence of loose kidney through the large sympathetic ganglia.

5. Patients with direct local mechanical results from the influence of loose kidney.

6. Patients in whom loose kidney is only a part of a panptosis of the abdominal viscera.

In all these cases abdominal supporters are indicated. In many cases sufficient relief is obtained that no further procedures are necessary. In others enough relief is obtained to warrant more radical procedure; while in a very small proportion of cases surgical intervention is demanded at once, particularly in those cases which come under class four and five. A number of each class of these cases have been seen by me, but in only a few have I felt myself justified in operating. Those on whom I have performed nephropexy have had an uneventful recovery, but I have insisted on other abdominal support, taking up all the relaxation by the use of well-fitting inelastic abdominal supporters, and these can be made in the household with more certainty of satisfaction, than has been given by the supporters furnished by the supply house. Instead of having perineal bands to keep the supporter in its proper place, the hose supporter can be atached and serve the purpose that they do in a straight front corset. For temporary use, I frequently use mole skin adhesive plaster, shaping it to the abdomen.

Second in frequency to movable kidney the surgeon is asked as to the advisability of operating for Bright's disease. In certain cases which are comparatively rare, decapsulation is a life-saving measure. It has been used successfully in eclamptic and in post-anesthetic anuria. Edeboles, in his book on this subject, summarizes the matter as follows: "In diseases which, like chronic nephritis, run a protracted course, years of patient observation are required to determine and establish finally and definitely the value of any method of treatment."

The intrarenal relaxation following decapsulation has proved of transient value in many cases, yet the pressure and obstructive symptoms in interstitial Bright's disease is not limited to the capsule and in parenchymatous inflammations kidney cells are destroyed by granular or fatty or hyaline degeneration induced by systemic intoxication, either infections such as that coming from scarlet fever, septicemia, syphilis or tuberculosis, or from alcoholic excesses.

Before any surgical measures should be considered, the results of the most consistent medicinal treatment should have been proven valueless. Bright's disease owes its chief surgical importance to the fact that many consultation cases are seen by the surgeon suffering with intra-peritoneal symptoms or general symptoms with visceral crises reflexly the result of kidney inefficiency. Many of our hepatic or gastro-intestinal cases will

show no improvement until after we have induced a period of hypernephritic excretion.

An examination of the kidney must be made by palpation, by percussion, by bimanual examination, by urinalysis and frequently by cystoscopic examination and catheterization of the ureters. Any case in which nephrectomy is a probable necessity should have the benefit of ureteral catheterization, or at least have a knowledge of the functionating ability of each kidney by urinary segregration. Both kidneys may be involved in a process that would not admit of compensation were one to be removed.

Urinary analysis may not show a serious lesion of the kidney until a time too late for surgical interference. I successfully extirpated a four-pound sarcomatous right kidney a year ago in which no pathologic findings were found in the urine on repeated examination. Pyelonephritis during pregnancy is a condition we can anticipate with fear and dread. In many cases it means a sacrifice of the life of the child in order to prevent the necessity of a nephrotomy or a nephrectomy upon the mother. The pressure on the ureters and the extra toxemia induced by the pregnancy being factors that must be weighed most carefully.

Tumors of the right kidney or movable kidney is to be differentiated from a distended gall bladder. One of our prominent authorities says that retro-peritoneal tumors are always immovable and makes no exception, as should be done with the kidney, for it frequently moves with respiration. An enlarged and floating kidney may be found in any place in the abdomen. The attacks of pain coming from a torsion of the ureter may simulate gall stone or renal colic. It may be sufficient to produce an adynamic illeus with all the symptoms of an obstruction of the bowel. In examining for the kidney, the colon resonance is always superimposed. In enlargements or tumors of the gall bladder or of the spleen, the colon tympany is displaced downward, no resonance being found between the tumor and the margin of the liver on the right, or over the spleen on the left.

Ten years ago nephrotomy and nephrectomies were rare—so-called surgical kidney being the one probable indication, and renal calculus thought to be the sole cause. Our present advanced methods of examination, however, have given us knowledge of kidney conditions demanding even nephrectomy, that before were palliatively treated as bladder trouble. Chief among these is renal tuberculosis.

This condition, like most forms of tubercular infection, is insidious in character; many cases giving a history of years standing. Commonly these cases are wholly cystic in their symptomatology. The chief and only symptom often being a bladder irriability without any urinary or bladder evidence of disease. Some peculiar characteristics of the urine from a tubercular kidney causing this vesical irritation. Kelly reporting his experience with sixty-two cases of renal tuberculosis, says the average duration of symptoms is three and a half years. One case with history dating back thirteen years, however, had at time of operation a small area of apparently normal secreting tissue. Kelly further says that all cases come from an infection through the blood, and that an ascending infection from a tubercular bladder is seldom or never found, and that the bladder is infected from a diseased kidney. These cases go without febrile symptoms until a mixed infection occurs.

The urinary findings of tubercle bacilli is neither constant, certain or positive; many cases never show them, others require the maximum amount of skill to demonstrate—others report finding tubercle bacilli when they have a urine infection with the smegma bacilli. Guinea pig inoculations give the most positive evidence of a tubercular infection—subcutaneous and intraperitoneal injection of the urinary sediment causes a general and rapid tubercular involvement, which is easily recognized.

Tuberculin injections give a positive reaction and commonly in addition to systemic symptoms, a marked local reaction in the form of intense pain in the affected kidney.

Extirpation should be the rule in every case as soon as diagnosis is made. A case recently operated upon by me gave a history dating back about ten years, principally of vesical disturbance. Operation was accepted by the patient as a dernier resort, a mixed infection having occurred and chills, fever up to 104½ deg. and pulse running to 160, being the condition at the time of first seeing her. A tumor as large as the body of a ten-pound baby was plainly felt occupying the entire left half of the abdomen. On removal, which was done under hyoscine anesthesia, the kidney was found to be filled with multiple abscesses. The opposite kidney seems to be uninvolved up to the present time, and is doing its compensatory work in the best way. Albumen and sugar used to be the "ultima thule" of urinary analysis, now we hardly know when to stay our work. Cryoscopy or the freezing point of urine as compared with blood, requires a long training and a large experience before one's technique can become perfect and our results reliable.

Kummel says of this procedure, "We have often noticed that the results of the examination of the same patient by several persons showed wide variations." Its value, however, is unquestioned, and as we learn a simpler technique, or become more proficient in its use, we shall find that a definite knowledge of the molecular concentration of the blood and urine is a valuable asset in differential diagnosis and prognosis. The electric conductivity of urine is another laboratory method of recent introduction.

The use of indigo carmine and methylene blue in connection with cystoscopy gives us knowledge of the functional ability of the two kidneys, especially in connection with the catheterization of the ureters. The subcutaneous injection of phloridzin causes a healthy kidney to excrete urine containing sugar in fifteen to twenty minutes. The use of the X-ray is now universal—every cross-roads having a machine and an "electro-therapeutic" laboratory. In the hands of a good operator, fine results can be obtained by radiography, showing in 95% per cent of all cases the presence or absence of stone in the kidney.

The occurrence of hemorrhage in the urine is always suggestive of renal calculi, although tumors or tuberculosis may produce bloody urine. Urinary calculi produce attacks of pain peculiar in character, paroxysmal and of great severity. Tuberculosis usually is accompanied by other signs and symptoms of the dyscrasia, while a tumor may show nothing until its size becomes prominent.

The differentiation of the several surgical diseases of the kidney is often a simple matter—but more frequently it taxes our utmost skill and most careful diagnostic aids. Many cases come to us too late for any premanent hope of complete recovery. Others have been treated and mistreated until their faith and confidence in medicine and surgery has disappeared. Closer study, more careful examinations, and less hesitancy in advising needed surgical procedures will place the surgical diseases of the kidney on the same plane as we now have the diseases of the appendix, the gall bladder, the uterus and the gastro-intestinal tract.

359 Union Building.

MEDICAL women of Lincoln, Nebraska, have organized a medical club with a membership of twelve. At a recent election Dr. Laura Brown was elevated to the presidency and Dr. Mabel Dunn to the secretary-treasurership.

SOME CASES OF REINFECTION WITH SYPHILIS.*

A. U. WILLIAMS, M. D.

HOT SPRINGS, ARK.

IT is not my intention to weary you with a long discussion as to the frequency or possibility of reinfection with syphilis, but to present the history of some few cases for your consideration. Authorities state: "As a rule syphilis attacks the individual but once in a lifetime," but admit that a sufficient number of well attested cases have been published to establish the fact that reinfection does occur.

Taylor says, "There have been published up to date (1904) 160 cases of syphilitic reinfection, and it is safe to say, allowing much latitude, that not more than thirty of the whole number are authentic instances.

White and Martin say, "Syphilitic reinfection is exceedingly rare, but it unquestionably does occur in some few cases."

One of the most eminent surgeons of this society told me recently that he had never seen a case.

In my experience of twenty-two years in Hot Springs I have seen a number of cases in which I have suspected reinfection. In many the history of the first attack was indefinite, and unreliable In but very few cases was the history sufficiently plain to make anything like a probable diagnosis of a second attack. However suspicious the case might look too much had to be taken for granted, to report the case.

I have notes of two cases, however, so very much alike, in which the symptoms and history are so plain, that I think I can safely claim both as cases of reinfection.

These two cases were in young men of about the same age. One from Kansas, the other from New York. Both came under my care in the summer of 1893. The disease had existed for months. Both had extensive ulcerations, which they had been unable to get under control. Both cases responded nicely to the treatment in connection with the baths. They left Hot Springs apparently well, neither had any recurrence of the disease, and were free from all symptoms of any specific infection for a period of seven years.

In the summer of 1900 both returned to Hot Springs with well developed cases of papular syphilides. In one case the chancre was scarcely healed and was still in evidence in the other.

Both gave a clear and precise history of exposure, following the usual period of incu-

*Read before the Mississippi Valley Medical Society at Columbus, O., October 8-10, 1907.

bation a typical hard chancre appeared. In forty-two days papular eruption accompanied by mucus patches. Slight enlargement of the glands. Both were typical cases of secondary syphilis. Both responded readily to treatment.

The points that I wish to call your attention to in these two cases are, first, that there is no doubt that they had syphilis in the first place. Second, the period of time, seven years that elapsed, from the cessation of treatment, the complete immunity from all symptoms during this period. Third, the clearness of the history of the case. The exposure, the period of incubation, the appearance of the chancre, the secondary eruption, mucus patches, and especially the regular chronological order in which all of these secondary symptoms appeared.

These men are both married and settled down. One a prominent business man in Memphis, Tenn. I see him occcasionally, he enjoys perfect health. The other lives in Kansas and was well when last heard from, two years ago.

THE FREQUENT INTERDEPENDENCE OF DISLOCATED KIDNEY, GALL-BLADDER TROUBLE AND APPENDICITIS.*

EARL HARLAN, M. D.

CINCINNATI, O.

A ten year study of this subject has impressed the author with the serious import of dislocated kidney.

He discusses the status of dislocated kidney as a pathological entity capable of producing symptoms of functional and physical derangement, primarily, within the organ itself, and secondarily on the part of the stomach, cholecyst, bowel and appendix.

He divides movable kidneys into two classes: First.—Those with, and second, those without clinical pathology, e. g., bedside symptoms, and calls those of the first division "movable kidneys," in contradistinction to those of the second class, which he places in the category of "dislocated kidney," the latter term being more applicable as a pathological expression.

From three to five per cent of movable kidneys are of the second class, and therefore demand surgical interference.

He justifies the belief, in the minds of those who doubt or scoff at the existence of the pathology of a movable kidney, on the grounds that, although they may have seen many freely movable kidneys, they probably have not come into contact with a pathologically dislocated kidney, or if they have that they have been misled in the diagnosis of the latter. He supports the claim that a "dislocated kidney' may present the clinical picture of gastric irritation or ulcer, obstruction to the bile outflow with attacks of jaundice, partial obstruction of the intestine, or appendiceal irritation or appendicitis, without presenting any symptoms or conditions, other than displacement, which tend to involve the organ itself, pathologically speaking, with a number of reports of misoperated cases.

He cites the recent great work of Suckling of Birmingham, England, who proved that insanity is often produced by dislocated kidney, and reports the cure of twenty-one cases who underwent the operation for correction of the pathological displacement. The diagnosis was made in these cases by measuring the amount of kidney excrement and comparing with that of the normal kidney. He also refers to the work of Harris of Chicago in establishing the pathology of these cases.

He traces the relationship and pathological dependence of gastric trouble, bile-duct and bowel obstruction, and appendiceal irritation with colic with dislocated kidney, and emphasizes the great importance of making an exact diagnosis in all cases of chronic indigestion with obscure symptoms and conditions, citing cases, as stated, which had undergone a mistaken diagnosis and having been operated upon for appendicitis or gallstones, wherein the primary lesion was a dislocated kidney.

He says that this lesion more often escapes notice and diagnosis than all other abdominal lesions combined.

He summarizes the salient features of his paper in the following paragraphs:

First.—That as dependent pathology, accompanying the primary lesion of dislocated kidney, gall-bladder trouble and appendiceal irritation of a severe nature, are of frequent concomitant occurrence.

Second.—That many cases have undergone operation for appendiceal trouble or gall-bladder trouble wherein the causative factor was a dislocated kidney, the latter producing pressure interference to the bile outflow or bowel current.

Third.—That all cases presenting for abdominal treatment, complaining of indefinite and recurrent distress, discomfort and pain, these attacks being accompanied with the presence of an excess of stagnant gas at certain points in the bowel, and in which the involvement of the stomach, gall-bladder and

*Abstract of a paper read before the Mississippi Valley Medical Association at Columbus, O., October 10, 1907.

appendix are more or less equal, should receive the most careful and repeated consideration from the physician, in order that a distinct differential diagnosis may be concluded.

Fourth.—That in the vast majority of instances, a freely movable kidney presents no pathology on the part of the organ itself, and that this immunity may cover a considerable space of time, after there appears symptoms of functional and mechanical disturbance on the part of the stomach, cholecyst and bowel.

Fifth.—That, on account of the wide and uncircumscribed range of pathological symptoms produced by a dislocated kidney, it is more often liable to proceed undiagnosed than another symptom producing abdominal lesion.

Sixth.—That permanent and complete relief result only from a correction of the primary lesion with its dependent pathology.

FIFTY thousand dollars will be expended by the Fabiola Hospital, of Oakland, California, in the erection of a new surgical building. This is the first of a series of buildings to be erected on the pavilion plan.

PRACTICAL LAY INSTRUCTION.—The reverse side of the transfers used on the various surface lines of New York, contain, on certain days, instructions to consumptives and the addresses of the various tuberculosis dispensaries. The privilege is a courtesy from the business firm which usually advertises there.

SLEEPING SICKNESS.—Sleeping sickness is responsible for a reign of terror in Africa. Report says that the epidemic has progressed to such alarming degree that its advent in a family is the signal for relatives to despatch the victim to the streets, and it is not uncommon to see dead and dying along the road sides.

THE THERMOMETER IN DIPHTHERIA.—The physician should remember that in diphtheria, the thermometer is of little assistance. The degree of fever does not sustain any fixed relation to the amount of blood poisoning, as pointed out by J. Lewis Smith many years ago. A constant elevation of temperature in diphtheria should lead the physician to examine for some complication, possibly nephritis.

EXAMINATION FEE RESTORED.— Because of the vigorous and determined protests lately inaugurated by the medical profession of the country, the Equitable and Mutual Life Insurance Companies, of New York City, have elevated their examination fees to the old standard of five dollars.

SELECTED ARTICLE

THE STORY OF ROSE AND EDWARD.

Miss Rose—was a little over twenty-two. She was a bright, cheerful, happy girl, and this was her happiest day. Not only because on that day she was graduated from Barnard with high honors, but Edward—dear Ed whom she loved and looked up to for so many years, had proposed last night, and the passion, romance and aroma of that proposal still lingered with her. And how the plans and hopes and dreams kept chasing each other in her fertile prain. She had decided where they should live, where they should spend their summer, how she should bring up her children, etc., etc. And Ed was a husband to be proud of. Though but twenty-eight years old he had already achieved eminence in the legal profession, and his practice was more than he could attend to. And he was one of those rare specimens, a truly honest lawyer. Not honest in the legal sense, but honest in the true human sense. And kind-hearted, a gentleman in the noblest sense of the word and an all-round athlete. A man to protect a woman from every possible care and make her happy as long as she lived. So thought Rose and she was right.

They were married in October. They expected to stay away three months on their honeymoon, but they reurned after about three weeks. Rose was not feeling well, and traveling and staying in hotels didn't agree with her. She looked rather tired and fagged out, but that was natural. It was not natural, however, that after a week's rest she did not show any improvement. On the contrary, she began to look somewhat haggard. She had a little irritation in the genito-urinary tract, increased frequency of micturition, etc., but as this is not unusal in newly married women, it was not considered necessary to consult a physician. Things contined this way, getting a little better and a little worse, until the beginning of January. On the fifth of January she was taken violently and dangerously ill. Severe abdominal pain, very rapid but hard pulse, and threatening collapse. The physician who was called in diagnosed the case as ruptured tubal pregnancy. A consulting surgeon was called in and it was decided that in order to save the patient's life, an immediate operation was necessary, and though it was midnight the patient was quickly removed to—'s private hospital and operated upon. No signs of extrauterine pregnancy were discovered, but about three and one-half pints of a blood-stained and somewhat purulent serum were re-

moved. An examination of this serum demonstrated the presence of millions of gonococci. We have here to deal with a case of fulminant gonococcal salpinigtis. Both tubes were thickened and inflamed and they were removed. And so was the now useless uterus. The operation was a "success;" i. e., the patient recovered.

A confidential talk was had with Mr. Edward. He searched his memory for awhile —yes, some two years ago he had a very mild attack of—he did not know whether it was gonorrhea or something due to a "strain." It was very mild, it didn't bother him much, he went to his physician who gave him an injection and he was all right in three or four weeks. He never attached much importance to that attack and it had escaped his memory entirely. An examination of his urine, however, demonstrated the presence of shreds, and while no gonococci could be found in the urine, they were demonstrated in the expressed secretion from the prostate and seminal vesicles. The despair of Mr. Edward at learning that he was the unwitting cause of the tragedy can better be imagined an described.

Rose recovered, but you would hardly know her if you saw her. She aged ten years in ten weeks. She is making no plans, she has no hopes, she is dreaming no dreams—not for the present at any rate. Never again will she be the happy Rose that she was before she became Mrs. Edward. Never will her home be gladdened by the noise, romp and laughter of little children.

Who is to blame? Nobody. Rose certainly is not, nor is Ed, for he certainly would have had his right hand cut off—and his left one, too—rather than cause the woman whom he loved above all else in the world any pain or suffering. But he "didn't know" and we cannot be blamed for things that we do not know, and that we never were told that we ought to know. Should we blame those who insist that all knowledge of sexual matters be kept away from the people? Perhaps, but even they are more to be pitied than blamed. For they are generally sincere in their beliefs and we cannot blame them for their ignorance.

No, nobody is to blame, but it is the duty of those who see the light to spread the knowledge of sexual matters and of the dangers of venereal disease before the people, so that tragedies like those that have struck down our friends Rose and Edward may become rare or impossible in the future.

It would be an excellent plan if every man who indulged in promiscuous intercourse, no matter how rarely, had his urine and his prostatic secretion examined before marrying. This even if to his knowledge he never had gonorrhea. For there are gonorrheas without any subjective symptoms, gonorrheas in which the gonococci remain dormant, only to awaken into virulent activity at the first opportunity. And newly married life is such an opportunity.—Critic and Guide, May, 1907.

THE PARIS MEDICAL FACULTY has recently announced that henceforth the incumbents of the special chairs of anatomy, histology, physics, chemistry, and pharmacology will not be allowed to take positions as physicians or surgeons in the hospitals.

PUCK'S DISLOCATION.—The following rare dislocation of the tibia is referred to in a recent issue of Puck, under the head of Fashion, which is said "leads a woman to willingly cut her sleeves off above the elbow and then hustle to find $5.27 to buy cotton, silk or kid gloves to cover the end of her tibia.

OSTEOPATHS OBJECT TO FOUR YEARS' STUDY.—The Indiana Osteopathic Society, in semi-annual session at Indianapolis, decided by a unanimous vote to fight the State Medical Board ruling against the admission of osteopaths to examination who have not studied four years in an approved college. The fight will take definite form by the appeal of the case of John Ambrose Barnett vs. the State Medical Board.

THE SPITTER AND THE CUSPIDOR.—Tennessee has a new law which compels proprietors of stores and establishments, where people are accustomed to congregate, to provide a sufficient number of cuspidors for their use. A minimum fine of ten dollars or a maximum fine of one hundred dollars may be imposed upon persons failing to comply with the law. Likewise persons who are detected in the act of expectorating in public places are liable to a fine not to exceed five dollars.

THE recent death of Sir Michael Foster, at the age of 71 years, removed from the ranks of the British profession one of its foremost members, and from the profession at large an eminent worker in physiology. He was a pupil of Sharpey and of Huxley, both of whom he succeeded as professor of physiology. He was the author of "An Introduction to Embryology," founder and editor of the Journal of Physiology, and was successively demonstrator of physiology at University College, professor of physiology Univeristy College, Fullerton professor at the Royal Institution, prelector at Trinity College.

The Medical Society of City Hospital Alumni

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OFFICIAL TRANSACTIONS.

PRESENTATION OF A PATIENT WITH UNUSUAL ORBITAL GROWTH.

F. E. WOODRUFF, M. D.

ST. LOUIS.

THE patient is a married man, 42 years of age. He noticed about the beginning of the year some slight puffiness of the lower lid, then the beginning of this growth, which has continued up to the present time. He gives no syphilitic history, nor could any symptoms of the disease be elicited. His father's death was the result of an accident; his mother died of some heart affection, at the age of about 60; no brothers or sisters dead. Examination of the nasal passages negative. It was at first thought it might be the result of antrum trouble, but the findings at the examination were negative. He is here for your examination, and I would like to know definitely what is the matter with him. His brother thinks the swelling is a little less than it was three or four days ago. He has been under active antisyphilitic treatment for five or six days. There is constant pain which has been present for the last four months. He complains that the pain is all through the head and today it extends down into the teeth.

The President.—Has he any other trouble?

Dr. Woodruff.—No, we examined the liver and there is nothing there. We have found no tumor anywhere else.

DISCUSSION.

Dr. M. H. Post —I came here to acquire, not to impart information. Of course I might say that this is an exceedingly interesting case, but that is a platitude—we all know that. As to the diagnosis, we could not make one without studying the case very thoroughly. The points impressing me are, the position of the eye—crowded downward and outward—and the sensation you get, from palpating the eye, of something hard back of it, there is no resilliance, such as one gets from a blood tumor. The position of the eye, being pushed downward and outward, could incline me to think that the tumor does not arise from any of the bones of the lower part of the orbit; but that we have in this case a tumor growing from the apex of the orbit, probably on the nasal side. Has a thorough examination of the ethmoidal cells been made?

Dr. Woodruff.—Not a thorough one.

Dr. Post.—From its hardness, the slowness of its growth and position, I should suspect an osseous tumor growing from the nasal wall of the orbit. I should examine the man with that condition in mind. I should not be surprised to find an osseous tumor growing from the apex of the orbit on the nasal side. It did not strike me that there was hypertrophy of the upper maxillary bone. The lower margin of the orbit is very hard, but I believe that is an edematous condition. I feel complimented that you should ask me to discuss this case from the ophthalmologist's standpoint, but I think that it does not belong to the ophthalmic, but to the general surgeon.

Dr. Norvelle Wallace Sharpe.—I think Dr. Post is correct in saying that it is difficult, if not impossible, to make an estimate of this condition after but a five minutes' examination. Has there been a loss of weight?

Dr. Woodruff.—His weight has dropped from 145 pounds to 117½ pounds.

Dr. Sharpe.—It seems to me, too, that this is not a case for the ophthalmologist, but unqualifiedly belongs to the surgeon. In the tissues beneath the orbit to the nasal side it appeals to me that there is an enlargement of the bone itself. In that respect my findings do not argee with Dr. Post's. There are several conditions which may be present the more probable of which are a vicious syphilitic involvement or a sarcoma. I should rather lean to the belief that it is an osteosarcoma. The doctor would be justified in taking a section of this growth and subjecting it to critical microscopic examination,

* Clinical meeting of June 6th, 1907.

and if found to be malignant the sooner it is operated upon the better.

Dr. Louis Rassieur.—I examined this patient rather hurriedly, but I am inclined to believe it is a carcinoma arising from the antrum, and my reasons for thinking so are, first, the age of the patient, who is 42 years old; and second, the rapidity of the growth and great loss of weight, and lastly, the superior maxilla, seems to me unquestionably involved. If it were merely edema I think we could pit it on pressure. Another reason for thinking it carcinoma instead of sarcoma is that the lymphatics are enlarged. While sarcoma may show such involvement we most commonly expect the lymphatic glands to be involved in carcinoma. These glands are extremely hard. I think it comes from the antrum because the nose is completely obstructed on that side, and finally, the doctor has not made a test to show that the antrum is not involved. If the doctor would just incise over a gland and make a histologic examination it would quickly solve the difficulty. After the diagnosis is made, then we should commence with the treatment. If we find our diagnosis correct it would be justifiable to at least make an explorative osteotomy, then if, after getting in there, we believe we can do real good, make a resection.

Dr. A. Edward Meisenbach.—Whether carcinoma or sarcoma, the treatment stands preeminent. I believe, however, that this is malignant process and the relief of the patient is the first thing, and that cannot be accomplished any better after the diagnosis is made than before. The lymph node enlargement may be inflammatory, and show no tumor metastasis even in malignant conditions, leaving the surgeon in doubt, or even misleading him

Dr. Rassieur.—I think an exploratory incision should be made.

President Kirchner.—I have not studied the pathology of this condition, but those cases I have seen simulating this were sarcoma. When a case has reached this stage surgical intervention is extremely difficult, the ramifications are often more extensive than we would expect. I know of cases where operations have been attempted for tumors in this locality and have terminated fatally. The tumors are often so extensive that we cannot handle them surgically with much satisfaction.

Dr. Meisenbach.—Regarding the antrum and the sarcomatous nature of the case: It seems to me the involvement of the bone is not what we would expect from the pressure within the antrum, but it seems that the development externally is in a line toward the inner margin or the facio-nasal margin of the maxillary and not from the thinnest point of the antrum wall. Regarding the treatment, a complete resection of the superior maxillary would be necessary if this is a malignant condition.

Dr. Rassieur.—Where we don't know what the trouble is I think we ought to make an exploratory operation, then if we find we can do any good, let us make the operation as extensive as necessary.

President Kirchner.—Some will remember the case that was presented at the City Hospital some months ago, in which the tumor caused both eyes to project. At autopsy it was found to be osteosarcoma, originating in the ethmoid.

Dr. Luedde.—A short time ago I saw a case of osteosarcoma that had begun in the ethmoidal cells. Dr. Sluder first observed it. Dr. Clopton removed the superior maxillai and went as far back as possible, but it was impossible to get all the growth. Although the patient was relieved temporarily of all pain, it began growing again. The first ocular symptom manifested was a paresis of the inferior rectus muscle. The left eye turned up. Although there was a large tumor mass it did not show much superficial vascular development as one might expect in a sarcoma. So that seems not to be an absolute guide. The absence of the vascular development does not decide the question. Nor does the age determine the character of the growth. The patient I speak of was a colored woman about 45 years old. She died about six months after the tumor was first discovered. It had by that time pushed the left eye entirely out of its normal relations and destroyed vision in it.

Dr. Sharpe.—I wish to emphasize what I said, that the diagnosis cannot be made offhand. A section of the tumor should be submitted to the microscope. I am not in accord with Dr. Rassieur that we can make a diagnosis because two or three glands are involved. We find in these conditions the line of involvement often different from the classical type. Furthermore, I believe it is bad surgery and bad advice to pronounce such a case hopeless. The visible amount of change here might be produced by a very small amount of bony overgrowth. But I do think it imperative that that patient be examined quickly and, if, necessary, operated upon quickly. If the operation prove insufficient, or an operation is considered out of the question, try the Coley fluid.

Dr. Rassieur.—I referred to these lymph nodes merely because they are superficial and easily gotten at, more easily gotten at than the tumor, and a histological examination of one might help to clear up the diagnosis.

Dr. Woodruff, in closing.—The patient has been referred to a surgeon for diagnosis and treatment. An exploratory operation has been suggested and may be done, but I was anxious to see what this body would say in regard to the condition. The glandular involvement has been present only the last two or three days. There is no cachexia as we would expect in malignancy. No one seems to think it is leutic, and the diagnosis seems to lie between that and an otseosarcoma. We are giving the iodide treatment merely to see what effect it may have. He is taking 65 drops of a saturated solution of potassium iodide, increasing the dose five drops a day.

PRESENTATION OF SPECIMENS.

C. H. SHUTT, M. D.

ST. LOUIS.

DIAPHRAGMATIC HERNIA.

THE first specimen is a diaphragmatic hernia which did not produce death, the patient having sustained the injury a number of years previous to his death. He died of typhoid fever. He was 58 years old and had received the injury a number of years before, two ribs being broken. He entered the hospital suffering from a typhoid condition and later perforation occurred. At operation the perforation was found. There was a general peritonitis and he died in a short time. There were many ulcers of the ileum. The patient lived from October 28th to November 8th. Autopsy showed profuse peritonitis, and an old diaphragmatic hernia and an old fracture of two ribs.

CARCINOMA OF THE STOMACH.

The next is a carcinoma of the stomach, in which pylorectomy was done by Dr. Brown. The patient was a white man, single, 46 years of age, and for several years had used alcohol to excess. There was no family history of tuberculosis or malignancy. Patient had syphilis in 1888 and received treatment at Hot Springs and elsewhere. The patient had griping pains in the stomach that often awoke him from sleep. He weighed about 145 pounds. Vomited occasionally, corrected by dieting. From April to November his stomach gave him no further trouble. In September while in Texas, he felt well, imbibed too freely in alcoholics, was arrested and spent fourteen days in jail, living on underdone pork, etc., and since that time has had this condition of the stomach. Abdominal Examination: abdomen scaphoid, veins prominent, superficial fat scanty. The stomach could be palpated with thickened lower margins, the lower border extending within five inches of the symphysis pubis. Examination of stomach contents showed presence of lactic acid and absence of hydrochloric acid, combined acidity was 81. Microscopic findings confirmed the clinical diagnosis. After the operation the patient improved considerably so that he felt like leaving the hospital. Dr. Weber made the final notes on the case May 6th. The patient requested his discharge against the doctor's advice, he was apparently in fairly good condition.

SHAGGY HEART, OR PERICARDITIS WITH ADHESIONS.

The third is a good specimen of shaggy heart, or pericarditis with adhesions. The patient entered the hospital March 7th and died on the 14th. He was 33 years of age, single. He had been sick four or five days before entering the hospital. He had rheumatism in the ankle, then in the knee and then had pains about the heart. He had to sit up to get his breath. When he entered the hospital he was in great distress with considerable pain in the cardiac region, dyspnea, etc. The area of dullness was greatly enlarged, heart sounds muffled, no perceptible murmur, pulse weak. On auscultation, slight friction sound on the lower border. The diagnosis was pericarditis with effusion, pleuritis and acute articular rheumatism. That was on the 7th of March. On the 12th the temperature was 103.4 deg., respiration 30, pulse 100, patient delirious. It seemed probable that there had been a change to a purulent condition. Patient did not complain of pain, and there were rales all over the left side. At 5:30 p.m. the urine contained pus. The diagnosis was changed to arthritis, pleuritis, purulent pericarditis and cystitis. The urinalysis the first time was practically normal, the second showed a great number of casts and the last examination showed a considerable amount of pus and a few granular casts.

DISCUSSION.

Dr. Sharpe.—Was there a paracentesis done in that case of pericarditis, and if not, why not?

Dr. Shutt.—The condition at first was only a hydropericardium, or perocarditis

with effusion, that is, for the first ten days. It is a question whether it is advisable to give a man the benefit of the chance of relief by that means with the possibility of infecting the pericardium, when the probability is that it is a condition that is not liable to become purulent. After it became purulent the patient was in such a low state of vitality that probably the doctor thought it best not to attempt it.

Dr. Rassieur.—This condition of the heart is not so uncommon, we see about one such case every year at the City Hospital. That hernia reminds me of the fact that congenital hernia of the diaphgram seems strikingly frequent. I have seen three babies at post mortem with large diaphragmatic hernia. I remember one in which a large portion of the intestine had passed through the opening. I also remember seeing at postmortem a suprarenal hematoma the size of a hen's egg.

Dr. Meisenbach.—As to the size of the specimen, it is so shrunken one can hardly speak of that positively. An important question is whether there was involvement and thorough removal of the lymph nodes. In so many of these cases we find that the patient's opportunity for an early operation is lost simply because the doctor tries to give the patient relief by giving him first this thing and then that thing awhile, and the patient thus passes several months in comparative ease, and then it is too late to hope to permanently benefit him by operation. I know of one case where the percentage was over 80, and of that 40 per cent was free hydrochloric acid. The stomach contents were brownish in color and gave the reaction for blood, but that was brought into doubt for the patient had eaten meat a few days before and some particles of the meat were found in the stomach contents. We had to deal with an immensely dilated stomach with a cicatricial stenosis of the pylorus and the patient was losing weight in spite of a fairly good appetite, but he objected to operation. He was operated on later, and an old cicatrix with beginning cancer found, but succumbed to pneumonia. By means of medication, by the administration of alkalies if hyperacidity exists, by lavage, and careful diet, these patients can be relieved for some months, until it is too late for operation to be of benefit other than temporary relief. Motor deficiency is the indication for surgical interference even in acid conditions. If we wait for the absence of hydrochloric acid the disease has become too extensive, or the patient so reduced that we can scarcely hope for a cure, and seriously endanger his life by radical or even palliative operation.

Dr. Jules M. Brady.—In regard to this specimen of fibrous percarditis, which Dr. Shutt has shown, it might be well to think of the outcome of this condition had not the patient died. It would be an impossibility for such a large amount of fibrin to be removed, except by the formation of connecting tissue between the parietal and visceral layers of the pericardium that necessarily would cripple the heart's action very much. The interference with cardiac function would of course depend upon the extent of the adhesions. A total obliteration of the pericaridal sac has been termed by the Germans concretio cordis. The condition at times runs a latent course, and may not be suspected until revealed post mortem; at other times the heart's action is greatly embarrassed, causing passive congestion of the abdominal viscera and giving rise to the condition known as percardial pseudo-liver-cirrhosis.

President Kirchner.—I believe the literature does mention such cases. I have a number of times repaired the diaphragm for other injuries, for stab wounds and gunshot wounds, and it is a thing that should be done, as illustrated by this specimen. There are not many cases of diaphragmatic injuries and hernias reported. The subject has not received the attention that it should. Most of the cases on record are post mortem reports. Another class of cases is that of congenital hernia. In all cases of diaphragmatic injury that injury ought to be repaired. The first thing that happens when the diaphragm is injured, as a rule, is the effort made by the omentum to plug up the opening. I have seen cases of stab wound of the chest where the omentum had passed through the opening in the diaphragm and would be on the outside of the chest. In such a case as has been presented the injury could be repaired by resecting a rib. If there is an injury in the chest it can be easily reached. Or in cases where it is necessary to do an exploratory laparotomy the diaphragm can be pulled down and kept in place and than the repairs can be made. In regard to the stomach case, I saw that patient today. He is doing very well, is able to eat ordinary food, and does not complain of any symptoms at all. The question of involvement is important. The surgeon ought to get at these cases in the early stage. It is not good practice to give them palliative treatment that will obscure the symptoms of the disease In the early stage much can be done to help them. Mayo has simplified the procedure greatly. He has shown that the glands on the lesser curvature extend up

farther than those on the greater curvature, and the glands in this case were very much involved, and I believe the operation was a palliative one. However, the patient now goes about with a great deal of comfort, and his stomach does not trouble him. I have now a patient at the hospital who had a partial gastrectomy performed and who is up and about and is hungry all the time. I had another such patient two or three years ago. He was a laborer and has gone back to his work. The Mayo operation is a very neat one, and the results are gratifying. I have never met with such a specimen as Dr. Brady presents. These cases of pericarditis are always interesting. It is sometimes difficult to know where to draw the line, to know when the case ceases to be medical and becomes surgical. Ordinarily paracentesis is done and I believe can be done aseptically and with safety. The diagnosis is not always easy I remember one case in which a number of excellent internists had made a diagnosis of pericarditis. Everything was typical of pericarditis, and yet we found at operation that the fluid was in the pleural cavity. Fluid in the pleural cavity will often push the heart to the other side, so that it is not always easy to make the diagnosis.

Dr. Meisenbach.—Was that the case operated upon in 1901 or 1902?

President Kirchner.—Yes. I meant to convey the impression that the belief in the diagnosis of pericarditis was strong enough to encourage operation. There was a difference of opinion.

Dr. Meisenbach.—That was a case that developed after a pneumonia, I remember I had been asked in to see two or three operations on other patients, and afterward was was asked to see this man. He was in a critical condition. The thorax was distended and there was a dull note over the anterior and lateral thorax wall and a distinct cardiac impulse over the normal cardiac area. I took a little time to go over the case. I found what I considered compression sounds in the upper part of left thorax, however, I did not turn the patient over or have him sit up, because it was thought rather critical to do that.

One of the prominent physicians in the city called at that time, and he thought it was a case for an exploratory aspiration of the pericardial cavity, and it was done that evening at 7 o'clock. The fluid was purulent, and the diagnosis was clinched and the operation set for the next morning. I was present at the operation, and when the doctor put his hand in the thorax out rushed a lot of fluid. The heart was beautifully displaced to the right side after the opening and introduction of the hand. I had been unable to find the oblique position to the right that would tell me there was a pericardial effusion. I did not find the evidences in the posterior region, because it was not thought wise to have him exert himself. The heart could not be detected to the right of the sternum prior to operation. Delicate ahdesions doubtless held the heart in its normal place, and when these were broken by the operator's hand the heart was pushed to the right side by the pneumothorax. I made no positive diagnosis, but could not quite agree to a pericardial effusion, for the reason stated.

Official report from the twenty-one German universities shows a total registration of 7,219 medical students for the winter course of 1906. This is a rather high total, as in the winter and summer terms of 1905 and 1906 the enrollment was respectively 6,080 and 6,570. There are 104 female students pursuing medical work in Germany.

Sulphuring Fruit.—California has been greatly agitated over the promulgation by the Department of Agriculture of the regulation limiting the amount of sulphurous acid in dried fruits to 0.35 of 1 per cent. As the German government, which is probably the most rigorous in the world in its regulations concerning food adulterations, allows 1.25 of 1 per cent in the same products, it would appear as if our government had gone to an extreme.

The State and Syphilis.—It is now being urged in many countries by the leaders of medical opinion and social reform that governments should take steps to control the spread of syphilis. This disease is the cause of a vast amount of ill-health, and is responsible for many deaths. In the British army it costs the nation about $15,000,000 annually for sickness and about $20,000,000 in pensions and superannuations, or a total of $35,000,000 a year. The disease may be considered from the moral, social and legislative standpoints. The first of these came more within the range of the church, while the second was one that the medical profession should interest itself in. By legislation the governments of countries might do much by arranging for lectures, the distribution of tracts and the providing of places where syphilis might receive proper treatment. It is certainly a serious blot on our modern civilization that this disease should have free scope to afflict the innocent and guilty alike.

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A. F. KOETTER, Otology.
T. A. HOPKINS, Genito-Urinary Diseases.
ROBERT H. DAVIS, Dermatology.

Editorial Rooms, Suite 319-321 Century Building, St. Louis.

EDITORIAL

Who Is to Blame?

IN another department we reprint the pathetic story of Rose and Edward, a narrative which is not especially characterized by literary merit, but one which tells a story which is lamentably often true to life. The uncured gonorrheic who in ignorance of his condition takes this disease to his marriage bed; the happy bride, full of plans and hopes for the future; the wreck of one life and wretchedness of another, and *who is to blame?* We cannot agree with the author that no one is to blame. It is very well to talk of educating the laity as to the far-reaching effects of this disease and the difficulty of its cure, but there is another class who should have the same subject preached to them until they accept its truth and are governed by the facts. The laity would not believe that gonorrhea is a simple disease which should be cured in a week, or at most a fortnight, were there not a lot of physicians who foster such an error. The physician who treats gonorrhea who does not avail himself of the aid of the microscope is not doing justice by his patient or the public, yet in this the fourth city in this great country we know of many physicians who determine the cure of a case on the presence or absence of discharge!!! How few of your medical neighbors own a microscope, or know how to use one if they did own it! And then talk about who is to blame!

Possibly today the graduate in medicine is so taught that he feels his dependence on this instrument to such a degree that he will not hang out his sign until he is properly equipped therewith, but we doubt it. The campaign of education is good, let it come fast and thorough, and let it begin with the medical profession where it is most needed. In no other one point does the profession so ignore its responsibility and fail in its duty. Innocent womankind pays a penalty which should emphasize the enormity of the offense. True none of us is omnipotent and the disease in some of its forms seems a worthy opponent for a power that approaches omnipotence, but it is up to us never to look upon this disease as insignificant; it is up to us to use the microscope in dealing with it and in determining a cure, and it is up to us to urge against matrimony in every case where the least doubt exists about a cure, or where a considerable period of health has not been determined.

Who is to blame? Not alone the medical profession. But in so far as the medical profession is to blame let the evil be remedied, and that rapidly.

The Resuscitation of the Apparently Dead.

THE fear of burial before death is deeply impressed on the human mind, and no matter though it be demonstrated even the chance of that such an accident is so infinitely remote as to be rarely, if ever, a legitimate cause for apprehension, it still weighs heavily on many minds. Embalming methods of the present day preclude such a possibility, but they also preclude the possibility of the restoration of life to the apparently dead—they make death an immediate certainty. The establishment of the fact of life is much more important than the determination of death. If dissolution has not been complete the restoration to functionating of the vital organs is an urgent problem, and one which every physician has to meet with sufficient frequency to give him interest in the subject. Asphyxia of the new-born, asphyxia from anesthetics and gasses, narcotic poisoning and drowning give a wide range to the possibility of being near to the dividing line and being brought back to life when life was apparently extinct. Devices purposing assistance to the restoration of life are as a rule not available at the time and place where the accident occurs. Poe, of Norfolk, Va., has lately devised an apparatus which may be of service in the operating-rooms of a surgical hospital, or in obstetric wards, but it will by no possibility be found in the vast majority of cases for which it was devised. We would not express an opinion on the merit of the device, as we have not seen it.

It is said to be "based upon a comparatively simple theory. It is modeled upon the human heart. The machine consists of cylinders which correspond exactly to the right

and left ventricles and right and left auricles of the heart. Each of these has an inlet and outlet valve, so that the work as performed is, after all, similar to that of the human heart. Each cylinder has its plunger, like any ordinary engine, and these are made to work simultaneously, pumping poisonous gases or water, as the case may be, out of the lungs and again pumping oxygen into them. The present model, which Prof. Poe uses with astonishing results, is of the simplest mechanism. The patient is treated by applying the pipes connected with the machine to the nostrils. The machine is connected with a tank containing oxygen and with a glass jar filled with water, and into this are inserted in turn the tubes connected with the cylinder. In operating the contrivance the valves are placed in the nostrils of the subject. The subject's mouth is incidentally kept closed while the gases are pumped out and the oxygen is being forced in. The device is designed to be used when men have apparently been killed by asphyxiation, narcotic poison and drowning, as well as those who fail to recover from the effects of anesthetics. Men who have apparently been frozen to death also are treated readily, and last, but not least, cases of utter intoxication may be restored quickly to sobriety in a few minutes."

At least it will fill a long felt want if it serves the purpose last mentioned.

Eggs.—The Medical Record gives the following ways of using eggs in therapeutics: A mustard plaster made with the white of an egg will not leave a blister. A raw egg taken immediately will carry down a fish-bone that cannot be got up from the throat. The white skin that lines the shell of an egg is a useful application for a boil. White of egg beaten with loaf sugar and lemon relieves hoarseness, a teaspoonful taken once every hour. An egg added to the morning cup of coffee makes a good tonic.

New York and New England Association of Railway Surgeons.—The seventeenth annual meeting of the Association will be held at the Academy of Medicine, New York City, on November 14-15, 1907, under the presidency of Dr. T. H. Dana, of Cortland, N. Y. A programme on subjects of unusual interest and practical value to the busy surgeon has been arranged. Dr. Robt. Dawbarn will deliver the "Address on Surgery" on November 14, and on the following day will give a clinic demonstrating his method of sequestration, which alone is well worth going far to witness.

MEDICAL PROGRESS

Comprising the Regular Contributions of the Fortnightly Department Staff.

GYNECOLOGY AND OBSTETRICS.

W. H. VOGT, M. D.

The Disappearance of a Pregnancy.—A study of hydatiform mole—(O. Polano, Zeitschrift fuer Geburtshilfe u. Gynaek., Bd. lix, Hft. 3.)—The following peculiar case is reported: Patient 28 years old, cessation of menses for three months had a bloody discharge for several days and a temperature of 39 deg.C. The size of the uterus was found to correspond to the size of a four months pregnancy, and to the left of the uterus a tumor about the size of one's fist was felt. The diagnosis of a pregnancy in the fourth month was made, associated with a left pyosalpinx, or possibly a tubal pregnancy. The operation proved the uterus to be as before mentioned, but the tumor on left side proved to be a cystic ovary, the right ovary was smaller, but also cystic. Both tumors were removed and the patient made an uninterrupted recovery. On the 19th day, post-operationem, the uterus was found to be soft but considerably smaller than before the operation. The uterus continued to grow smaller, without any bleeding ever having taken place, until after three-fourths of a year a normal sized uterus of 7 cm. long was detected. Since we can assume that a normal pregnancy of three to four months would not gradually disappear without any hemorrhage it is most probable that the author was dealing with some abnormal product of pregnancy. This assumption is verified by the results of the microscopic examination of the extirpated ovaries, which shows the well-known changes taking place in ovaries where a hydatiform mole exists. The author believes therefore, that this was a case of hydatiform mole in which resorption took place due to autolytic changes.

End-Results Following Operations for Cancer of the Breast.—(Willy Meyer. M. D., New York, Surgery, Gynecology and Obstetrics, July, 1907.)—In this report only the cases which have been operated by the author's method from September 1, 1894, to April 1st, 1907, have been collected. The radical operation was performed 86 times in 84 patients. Of these 83 were females and one male. The ages ranged between 20 and 80 years. Fifty-three cases were private patients, 31 were operated upon in the wards of the German and post-graduate Hospitals. Of the former careful records were kept of

their subsequent history, of the latter, however, four could not be traced. Deducting these four cases, which could not be traced there remain 80 for consideration. Of these 80 patients 28 are alive and well today, 9 having been operated upon less than three years ago; 4 or 5 per cent lived from six to eight years after operation; one of these died of regional recurrence, one of metastasis, two of diseases not connected with the original trouble. Twenty-eight lived three to twelve and a half years after the operation; 5 lived 3 to 5 years after the operation; 3 others though living have developed either local, regional, or metastatic recurrent growths; 40 died of the disease within three years after operation; two died shortly after the operation; one on the second day, of diabetic coma, the other after two weeks of secondary infection; 16 within 12 months, and 8 within 12 to 18 months, or 24 within 1½ years after operation. As regards the desirability of cleaning out the supra-clavicular glands even in the absence of clinical evidence of the presence of cancerous glands, the author says that his own experience does not speak in favor of such a procedure, since in 13 patients that remained well for 5 to 12½ years, this procedure was not followed. He thinks it well, however, to preserve the supraclavicular nerves. Edema of the arm was rarely observed in his cases, and the post-operative neuralgia or neuritis of the brachial plexus proved to be but temporary in every case. Every one of his patients has full use of the arm. Regarding the prognosis he states, that if the disease has reached an advanced stage, especially when the supraclavicular glands are involved there can be but little hope for a long freedom from recurrence. Everyone of his patients with such condition existing died in a very short time. In spite of this poor prognosis he believes that these glands should be removed for sometimes life may be prolonged more than seems at first possible. Judging from his cases adeno-carcinoma seem less favorable, as far as the end result is concerned than the scirrhus type. Every patient is urged to take a six to eight weeks course of treatment with the X-ray as an immediate after-treatment. Unless metastasis forbids it, every case should be operated upon by the radical method, skin should not be spared and the cuts should be made within healthy tissue as far as this can be done. The operation in order to have a good end result, should consist in removing both pectoral muscles with the diseased breast, glands and surrounding fat in one mass.

The Induction of Labor at Term.—(Joseph B. DeLee, A. M., M. D., Chicago, Surgery, Gynecology and Obstetrics, July, 1907.)—In this paper, which was read and discussed in the Chicago Gynecologic Society DeLee brings forth some entirely new ideas. He says that the obstetrician who watches his cases carefully will find that there are many disadvantages, not a few pathologic conditions and occasionally death as the result of allowing pregnancy to go beyond its usual length. This is mentioned simply as an index of the trend of modern obstetrics, and is the opposite of the supine expectancy that most practitioners have with regard to their obstetric cases. He says that every physician should make a careful study of each individual case with a view of preventing all possible accidents and complications at the full term of pregnancy. As regards pelvic contraction, special mention is here made of the funnel-shaped pelvis, and the importance and advantage of induction of labor at full term is emphasized. The author's method is the following: In computing in the usual manner the probable date of labor is decided upon —when this day arrives the patient is carefully examined. The genitals are thoroughly cleansed, likewise the examiner's hands, and by means of the hand and Perret s cephelalometer the probable viability and size is determined; then it is determined whether or not the head has entered the pelvis, and next the softness and patulousness of the cervix is determined. If it is then considered that the case is at full term, the patient is instructed that, if labor does not come on within a week, a date will be set for the induction of labor. In conclusion, DeLee states that he appreciates the danger of recommending this sort of procedure to the general practitioner, for it can be argued that the length of pregnancy varies a good many days, and a mistake of three or four weeks might be made, and the child then be delivered before it had a good chance of living. In the vast majority of cases, however, the pregnancy lasts 275 to 280 days, and we can come within a few weeks either way. If the baby came two weeks too soon it would make practically no difference to the baby, and if the mother should carry her baby two weeks longer this would also be safe.

Intestinal Paresis, Following Operations.—Brown and McCartney have had very favorable results from the use of physostigmin, 1-60 grain hypodermically every hour until relief is obtained or physiologic symptoms are produced.

THERAPEUTIC TIPS.

E. S. MCKEE, M. D.

Coal Tar Products Valued Lightly.—Dr. H. C. Wood, Jr., of Philadelphia, in a recent discussion before the Therapeutic Society, said that he thought that very few useful drugs had been put out by the manufacturing chemists, and that we would have been better off if Perkins had never discovered the coal tar products. The aniline dyes were cheap and gaudy, and did not last, and the coal tar drugs were in the some class. He believed that all the good coal tar products had done was neutralized by the harm.

Gout of the Fingers and Toes.—Dr. J. V. Shoemaker, in the Medical Bulletin, in a case of gouty inflammation of the fingers and toes, accompanied by pain in the extremities, extreme nervousness, headache, high arterial tension. The blood condition was good, the urine highly colored, acid, specific gravity 1029, uric acid abundant; no albumen or sugar. The doctor prescribed locally for the fingers and toes, three times a day, pure of oil gaultheria, which gave immediate relief. Galvanism 10 to 30 milliamperes once daily. To act more decidedly on the gouty system he prescribed the following:

℞ Strychninae sulph..... gr. 1-60
Arsenic trioxide..... gr. 1-30
Soluble iron pyrophosphate..
Quininae sulphate ..... gr. 1½

M. Fiat pil. S. Take one pill after meals and at bed time. The improvement was marked and continuous.

The Drug Treatment of Sciatica.—Primarily a calomel purge followed by salts; caution with morphine. In rheumatic cases salicylates; in syphilitic iodides; in gout colchicum. The following is probably one of the best all-round prescriptions:

℞ Acid salicylici acetyl..... 4.00
Acetphenetidini 3.33
Quininae salicylatis..... 1.33
Codeinae sulphatis..... 0.25

M. Fiat capsulae No. xx. Signa. Take one every two or three hours.

The following prescription is indicated in syphilitic and rheumatic subjects:

℞ Potassii iodidii..... 16.00
Sodii salicylatis..... 24.00
Tinct. cimicifugae.....
Syr. sarsaparilla compos...aa 60.00
Aquae.....q. s.ad.180.00

M. S. Take one teaspoonful in water after meals.

Alcoholic sciatica is best treated by the following:

℞ Tincturae nucis vomicae .....
Fluidextracti hydrastis.....
Fluidextracti cimicifugae.....aa 15.00

M. S Take twenty drops three times a day and at bed time, increasing the dose one drop every day.

Blisters, counter-irritation and painting with iodine are at times quite beneficial.

Hydrotherapy judicially administered has many cures to its credit in sciatica, and should be accorded due credit. The wet pack properly administered at night is a very excellent means of relieving pain as well as influencing favorably the neurotic process. Dip the leg of a heavy pair of trowsers in water at 65 deg. F. and place in position like a stocking. By means of a roller bandage this is kept in place and the leg kept in perspiration all night. Remove this in the morning and follow with a warm ablution and massage. Much improvement generally follows the use of ten or twelve packs. Subacute cases are much benefited by the half steam bath. The patient sits in a steam container which reaches only above the hips, and a temperature of 110 deg. can be endured for 10 or 15 minutes. He is then allowed to sit in a temperature of 95 deg. F. for eight minutes. The last three minutes a hot undercurrent douche of 102-112 deg. F. is applied to the affected limb. Alternating the natural swimming bath with the combined bath is of value. Ingestion of large quantities of water, the internal bath is beneficial. Compresses and Scottish douches in hydropathic institutions, complete baths with movements, warm packs and massage report from 80 to 90 per cent of cures.

Massage along the course of the nerve, even though painful is often beneficial through relieving the adhesions. It is as a rule not beneficial in true neuritis. This method of treatment, or better, mechanical vibration is of value in chronic cases where atrophy has commenced.

The Weir Mitchell rest cure is in some cases very sucessful, especially in those where the means of livelihood has been an active one, and the fixation of the leg in plaster of Paris is often good treatment. Rest in bed is in fact one of the initial requirements of this disease.

Baking the limb once daily is among the best means of assisting in the cure of this disease. This should be done in a heating apparatus the limb wrapped in a blanket and the temperature gradually run up and the application continued for at least an hour.

CLINICAL THERAPEUTICS

A forum of original experience, to which scientific contributions are invited. Responsibility for views promulgate limited to author.

THE MENOPAUSE.

W. T. MARRS, M. D.

PEORIA HEIGHTS, ILL.

A woman's life is attended by crises which are occasions for trouble, real or imaginary. Puberty, child-bearing and the menopause are all physiological processes, but nevertheless the majority of woman's ills center about the perversions of these functions. Perhaps as troublesome a portion of woman's ailments as the physician is called upon to deal with relates to that period of her life when she ceases to be fruitful. The majority of women cease to menstruate between the ages of 43 and 45. A few women menstruate up to 45 and 46, and more rarely up to 50. It is an unusual occurrence for a woman of the latter age to conceive, although the writer knew a woman of 52 to give birth to healthy twin babies. It is said that women menstruate longer now than in the generation preceding us. The average sexual life of a woman is usually given at 31 or 32 years. Menstruation seldom ceases abruptly, but is as a rule is more less irregular during the last two or three years of her sexual life. She may go three or four months without a show and she is congratulating herself on her successful passing of this critical period when a violent hemorrhage may occur. The character of the menstrual fluid may be very much changed at these periods and cause her physician to suspect malignancy, an interrupted conception, etc. Indeed cancer is much more likely to manifest itself at this than any other period, so the physician should subject every suspected case to a careful scrutiny especially should there be a history of malignancy.

The symptoms of a normal approach to and through this period varies with the woman's disposition and heredity. Her physical and psychic existence is undergoing an even greater evolution than occurred at puberty. Degenerative changes are taking place in many of the essential organs. The uterus and vagina begin to atrophy and shrink, the spleen and lymphatics decrease in size and function and the vascular system undergoes many modifications. She is likely at this time to suffer many symptoms which can be covered by the rather expansive term "neuroses." She is losing many of her little traits of sweet feminity, she loses much of her desire for applause from the opposite sex and emotion and sentiment in a measure give way to the plodding conservatism usually manifested by old men. In fact she is to an extent losing her sex and therefore becoming masculine both in manner and physique. Her voice loses some of its sweetness and may become harsh and grating and the hair on her face becomes stiffer often repulsively so. Her weight and general appearance rarely remain unchanged; she becomes some what emaciated or takes on flesh and acquires a generous embonpoint. If the former condition prevails she soon has a sunken flaccid abdomen and the breasts dwindle away to a mere nothing. If nutrition is unimpaired she becomes quite rotund, the breasts become larger than ever before owing to an increase in subcutaneous fat; the hips widen out and the waist line becomes almost obliterated. Many women are inclined at this time to disregard personal appearance only in that they want to present a respectable matronliness. They imagine themselves to be "growing old" and this mental effect made manifest in their appearance and dressperhaps hastens the decline of their erstwhile charms. However I here wish not to be misunderstood. It is mainly in the matter of superficialities and the little things that are so distinctly feminine in which these changes occur. Her morals and character remain practically unchanged.

A good religiously-inclined woman before the climacteric is likely to be the same after it is passed. Many women of bad repute become persons of unquestionably good morals after they have passed the change of life. The majority of prostitutes who pass this change and have their passions rendered extinct settle down to a life that is passably respectable.

As already suggested the woman who has difficulty in passing this crisis is prone to many symptoms neurotic in character. She is inclined to become moody and introspective and often pronounced hysteria and melancholia fall to her lot. Her vagaries may at times lead her to contemplate suicide and mild cases of insanity are at this period not at all uncommon. Hot flashes and sweating are symptoms rarely absent, and the condition is occasioned by a disturbance of the vasomotor centers. A pressing pain in the top of the head is experienced by the majority of women at this time. Vertigo is usually an accompaniment to this type of headache. She becomes nervous and despondent and broods over trifles. She is likely to complain of pain and tenderness in the left ovary and pains and weakness in the back. If she has suffered any chronic ailments they now become accentuated. An old cough and bronchitis are

likely to take hold of her with renewed activity and latent tuberculosis is now easily quickened. The woman may suffer in a great many ways and with a good degree of intensity and still not present a tangible basis for her symptoms. This should not deter the physician from going to the bottom of the case and giving it painstaking investigation; for while we can see nothing wrong sometimes, it should be remembered that the symptoms are real to the sufferer. The psychic symptoms in particular need judicious attention and the woman's mental and hygienic atmosphere should be made congenial. The bowels lose much of their muscular tone in consequence of which constipation and autotoxemia become manifest. The colon, that storehouse of dead feces, especially loses much of its tonicity by being so much of the time distended with excrementitious matter. Do not take the woman's word for it that she does not need physic. Keep the bowels religiously open with salines, alternated with small doses of calomel and podophyllin, say one-sixth grain of each. I have often found many of the symptoms due to the absorption of toxines and were removed by the persistent use of saline laxatives. For the flashes cactin and the triple arsenates of iron, arsenic and strychnine will afford much relief. Calcidin is also very serviceable in many cases on account of its alterative effect.

Strychnine and phosphorus are good remedies on account of their salutary effect upon the nervous system. Abbott's uterine sedative acts very nicely in calming the nerve-storms so frequent in women at this period. The formula is as follows: Helenin and viburnin, each grain a 1-12; dioscorein, grain 1-6; gelsemin, grain 1-250; avenin, grain 1-6; scuttellarin, grain 1-12. Two or three of these have a calmative effect without producing untoward results of any kind. In the congestive type ergotin should be added to this formula. I wish to emphasize the idea of keeping up good and effective elimination. In case of hemorrhage hydrastin and hamamelin are usually sufficient and in suspected cases of hemorrhage they should be given in anticipation of such an event. Should the bleeding be very profuse this treatment may be supplemented by a hypodermic of atropine and morphine.

In the catarrhal condition so often present hydrastin, berberine and xanthoxylin will give good results. Neuro-lecithin is of value in many cases. The woman's organs and emunctories should all be made to functionate normally. She should live mainly upon a fruit and farinaceous diet. A daily rub with coarse towels which have been previously in brine and dried is a procedure that gives gratifying results.

When to Drink Tea.—The London Hospital concludes that the original popular use of tea as a stimulating beverage with breakfast is justified and harmless; but that its indiscriminate consumption with meat foods or during proteid digestion is likely to be harmful—China tea, however, less so than the Indian variety, because of its lesser tannic acid content. Ginger beer seems to the Hospital to be practically without influence upon digestion.

Nature-Study in Country Schools.—Following his discussion of three important phases of the outlook on agriculture as expressed by Cornell University student—why certain youth desire to leave the farm, why others desire to remain or even to remove there from town, and what the agricultural college is doing for the farm youth—Prof. L. H. Bailey has prepared for the October Century a discussion of what can be done for the farm-youth by the common school. It is the author's position that the present country school should accept all wholesome conditions which it is placed, beginning with the sphere in which the child lives. In time, he prophesies, nature-study and agriculture will be as much a part of the country school as oxygen is a part of the air—a nature-study not something external or added to, but "a means of education, internal, central, essential, fundamental."

The House Fly and Its Connection with Disease Dissemination.—G. K. Dickinson (Medical Record), states that of the seven different varieties of flies found in our houses 98 per cent is the common house fly (Musca domestica). They are born in manure or in decomposing matter of any kind. Their tastes are indelicate and omniverous and they subsist on sputum, fecal juices and the slime and dirt that stick to exposed surfaces. The writer reports the results of experiments by various investigators. He declares that the importance of flies as a factor in the dissemination of disease depends largely upon other existing conditions. The possibility of a spread of any type of infectious disease by this insect has been conclusively proved. From experiments the relative danger is as follows: The dejecta, the proboscis, the crushed or ingested insect and the outside parts. The writer declares that scientifically speaking the number of flies in a community is in proportion to the carelessness of its sanitation. The greatest care should be taken to destroy as many of these insects as possible and to protect houses and their contents from those that remain.

THE MEDICAL FORTNIGHTLY

A Cosmopolitan Biweekly for the General Practitioner

The Medical Fortnightly is devoted to the progress of the Practice and Science of Medicine and Surgery. Its aim is to present topics of interest and importance to physicians, and to this end, in addition to a well-selected corps of Department Editors, it has secured correspondents in the leading medical centers of Europe and America. Contributions of a scientific nature, and original in character, solicited. News of Societies, and of interesting medical topics, cordially invited.

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Contributors should understand that corrected typewritten copy is essential to clean proof and prompt publication, and is much more satisfactory than manuscript. Original articles should be as condensed as justice to the subject will allow.

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Contributions and books for review should be addressed to the Managing Editor, 319 and 320 Century Building, St. Louis, Mo.

FAVORITE PRESCRIPTIONS

ANTINEURALGIA PILLS.—

℞ Strychninae sulph..... gr. j
Quininae sulph..... 3j
Ferri redacti..... gr. xv
Ext. gentianae..... 3ss
M. Ft. pil. No. 60. Sig. One three times a day.—The Med. Summary.

ACUTE TONSILLITIS.—In acute tonsillitis, first empty the bowels with mild chlo. mercury, followed with an alkaline, preferably rochelle salts; second, give the following:

℞ Sodii salcylatis.....
Potassii citratis.....aa gr. xl
Syr. pruni virg..... 3 iij
Aq. dest.....q.s.ad. 3 iij
M. Sig. Teaspoonful every two hours for a child of four years. Alternate this with small doses of aconite if fever is high; third, mild counter-irritants, applied externally in those too young to use gargles. If gargle can be used, chlorate potass. or borolyptol should be selected. In acute cases we use aconite after thoroughly clearing out the intestinal canal with most excellent results. Give small doses, but repeat often until the skin gets active, the pulse soft, and the congestion in the throat will often be aborted. —Canan, The Med. Summary.

ALOPECIA.—Sabouraud recommends the following:

℞ Ol. cadini..... 3iiss
Lanolin..... 3v
Acid pyrogallic.....
Hydrarg. oxidi flavi.....
Resorcin.....aa gr. xv
M. et ft. ungt.

℞ Lanolin.....
Petrolati.....
Ol. cadini.....aa 3iiss
Ol. betulae..... *m* xv
Hydrarg. subsulph. flav.....
Sulph. preciptat.....aa gr. xv
M. et ft. ungt. Med. Rec.

GASTRALGIA.—

℞ Arseni trioxidi..... gr. $\frac{1}{24}$
Ext. gentianae..... gr. ii
M. et ft. pil. One t.i.d. between meals.

In severe cases employ counter-irritation over the epigastrium by means of the following:

℞ Ol. cajuputi..... 3j
Tinct. capsici ether..... 3iij
Lin. camphorae ammon..... 3iv
For external use. Rub in for five to ten minutes once or twice daily. In still severe cases use following externally:

℞ Pulv. ipecac.....
Lin. crotonis.....aa 3ss
Adipis..... 3j
—Merck's Archives.

ENURESIS.—The following formulae by Sheffield are recommended in the treatment of enuresis:

℞ Ext. ergotae..... fl. 3iij
Ext. rhus toxicodendron..... fl. 3j
M. Sig. Five to ten drops every four to six hours.

In cases of incontinence due to hyperesthesia of the neck of the bladder irritating foods should be avoided, sitz baths employed, and the following antispasmodic mixture given:

℞ Ext. hyoscyami..... 3ss
Sodii bromidi..... 3j
Aq. anise..... 3j
Syr. simp.....q.s.ad. 3ij
M. Sig. One teaspoonful every four to six hours. Counter-irritation by means of mustard plaster should be employed over the lumbo-sacral region.—Jour. A. M. A.

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MEDICAL MISCELLANY.

NATIVES WORSHIP A DOCTOR.—According to an Associated Press dispatch from Berlin, Prof. Robert Koch, who has been over eighteen months in Central Africa studying sleeping sickness, is about to return to Germany. The latest reports from Africa assert that the professor has nearly reached the end of his investigations, which, so far as they go, are most satisfactory. Natives sometimes send messengers hundreds of miles to request Dr. Koch to come to their remote villages to cure their sick. His fame is so widespread that the tribesmen regard him as a wizard. In one large village near Lake Victoria, where Dr. Koch, with his assistants, went, the chief erected commodious huts, treated the white visitors as deities, and even paid reverence to the instruments. Hundreds were injected with Dr. Koch's remedy, atoxyl, with excellent results.

PREVENTION OF PERITONEAL ADHESIONS—Dr. E. Marvel, Atlantic City, N. J. (Jour. A. M. A., September 21), recommends the use of adrenalin chlorid after separating peritoneal surfaces to prevent readhesions. He allows the solution to flow from an irrigating nozzle over the oozing surface. The natural method of preventing adhesions is removing the exudation by absorption and the peritoneum can take care of it, but subsequent exudation should also be prevented. By its vasoconstrictor action, adrenalin shuts off further leakage, and the normal salt solution in which it is dissolved also serves to keep apart the separated surfaces. He uses a dram of the adrenal in chlorid solution to one quart of normal salt solution, making approximately a strength of 1 to 50,000; the temperature ranges 100 to 110 F. and the amount used varies from 500 to 1,500 c. c., according to the size of the cavity and the extent of the adhesions.

HOME-MADE BUTTERMILK.—It is now within the power of every household to have an abundance of that refreshing and healthful summer (also winter) drink—buttermilk. To the present time no one knew of any source of buttermilk except from the butter-maker; nowadays the butter-maker does his work so well that the buttermilk is entirely deprived of the delicious little grains of fat which add so much to its food qualities as well as to taste. True buttermilk, made direct from fresh rich milk, within a few hours, of the finest flavor and taste, nutritious and more excellent than the article as originally known, can now be prepared in any kitchen. This is done by taking a quart of fresh, rich milk, adding a pinch of salt and about a half-pint of hot water to raise the temperature to body heat, and lastly adding a tablet containing a pure culture of lactic acid bacteria. Place all in a pitcher, cover with a napkin, and let stand for twenty to twenty-four hours at the ordinary temperature, and there is your perfect buttermilk. The tablets are made by Parke, Davis & Co., the pharmaceutical and chemical manufacturers of Detroit, Michigan, and are called "Lactone" or buttermilk tablets. On the farm, in the process of buttermaking the cream is allowed to sour spontaneously and is then churned. The souring is the lactic acid fermentation caused by lactic bacteria or ferments. The difference between the new and old process is one of method and not result. In the old, the lactic fermentation is waited for and expected to occur spontaneously, with disappointment sometimes. In the new, the fermention pure culture is directly planted in the milk, and the desired fermentation is secured without fail. In Bible days, spontaneous fermentation of dough was depended upon to leaven or lighten bread, and failure frequently attended the process, the dough putrefying instead of fermenting, and was then lost. Finally, man learned to add yeast to the dough and not to depend upon spontaneous process, with the result of always securing the right fermentation and making a better and more nutritious bread. This new buttermilk process is like improvement.—Monthly Bulletin Indiana State Board of Health, June, 1907.

Pneumonia-Bronchial and Croupous

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A Physician's widow—would take several delicate children to the high pine lands of Florida for the winter. Best of care given them. References exchanged. Address, box L, in care of Medical Fortnightly.

Triacol (Alpers)—presents a preparation superior to other guaiacol compounds, being prepared with the guaiacol salts of potassium, sodium, and ethyl—morphine, which are tasteless, digestible, and active. Write for literature and sample. The Alpers Chemical Co, 4 and 6 White Street, New York City.

The greatest of Anesthetics.—We are living in an age of advancement in medicine as well as in all departments of life, and he who does not hustle today will wake up tomorrow morning looking into space and wondering where his neighbors are who were with him yesterday. I have been very much interested in Dr. Abbott's recently discovered hypnotic anesthetic, i. e., hyoscine, morphine and cactin comp. I have used it in a number of operative cases, with very satisfactory results. The anesthesia was perfect, except in two cases where, in addition, I used a very small amount of chloroform, which completed the anesthesia. I had none of the post-operative nausea which we so much dread following other anesthetics. In one case of weak heart where I could not use chloroform, the heart's action seemed to improve while under the influence of this hyoscine, morphine and cactin anesthetic. For about two years prior to using the H. M. C. anesthetic I had been using hyoscine and morphine as a hypnotic and analgesic, with such excellent results that I felt that I was not properly equipped without hyoscine and morphine tables in my hypodermatic case, but had never thought of its ever becoming an anesthetic. I feel that the medical fraternity is under great obligations to Dr. Abbott for the discovery and careful preparation of this much-needed and greatest of anesthetics, that is proving such a boon to suffering humanity. C. C. Cochran, Jacksonville, Ill.

Creosote and Chlorophosphate of Lime in Broncho-Pulmonary Affections.—Pure beechwood creosote is not only a first-class pulmonary and gastro-intestinal antiseptic, but it is also a stomachic and aid to digestion. Dissolved or diluted in a proper menstrum, it is well tolerated even by children, and it can be administered without inconvenience for long periods. On the other hand, chlorophosphate of lime is an excellent means of supplying to the system the phosphate of lime which it lacks in phosphaturia and in the deficiency of phosphates of tuberculosis, neurasthenia, rickets, etc. At the same time the hydrochloric acid which it contains has a beneficial effect on gastric secretions; it is a tonic of recognized efficacy. Pautauberge's Solution of Chlorophosphate of Lime with Creosote is, consequently indicated in all cases of broncho-pulmonary or gastro-intestinal infection, or where the system is debilitated. Besides its specific action on pulmonary lesions, it stimulates the appetite, aids digestion, increases the strength and vitality of the patient by developing the organism's means of defence. Finally, it is a valuable and even indispensable accessory in the curative treatment of tuberculosis.

The Use of Adrenalin During Ether Anesthesia.—(By Charles S. Venable, M. D., Charlottsville, Va., Virginia Medical Semi-Monthly, February 22, 1907.)—Recognizing that my experience in the use of adrenalin during ether anesthesia is but very limited, covering a course of only eighteen cases, and knowing the many fallacies attendant upon too early conclusions, I feel a great hesitancy in making this report. However owing to the uniform result that has attended its use, I am prompted to do so now. I found that 25 per cent aqueous solution of the standard 1 in 1000 gave the best results, and that by first pouring ether in the towel cone and spraying the adrenalin solution on it, depending on the ether to vaporize it sufficiently for inhalation, was the best mode of administration. Three to six minute intervals are sufficient for its use and a total of from one-half to one ounce of this solution is enough for an operation lasting from thirty minutes to an hour. The effects are a more uniform etheterization, the pulse becoming steadier, slower and of better character more rapidly than under ether alone; respirations are quiet and regular, the bronchial secretions are practically checked, and the progress of the operation is not interrupted. These cases were not selected, and among them were old alcoholics; two women over sixty years of age, one of them nearly eighty years of age. Three were very long tedious operations, lasting over two hours, and in none of the series was any stimulation required during the anesthesia. Recovery from the anesthetic was uniformly good; there was practically no post-operative shock, and no stimulation was needed in any one of the cases; only two patients vomited at all and very little nausea was complained of. From the foregoing facts I conclude that owing to the contraction of the smaller vessels the bronchial glands secrete less mucus, and there is better aeration in the bronchioles and pulmonary vesicles, less ether is required to produce anesthesia and there is less probability of ether pneumonia following. The adrenalin, acting generally from absorption, is a powerful stimulant; it materially lessens shock, lessens the capillary ooze at the field of operation, and is of great benefit to the much weakened patient.